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ABSTRACT

By examining prenatal care opportunities and health resources for low-income families, this paper investigates both the extent to which available health care in Virginia emphasizes a preventive approach and the extent to which Virginia's medically needy children have access to medical care. Statistics indicate that, as compared with the country as a whole, Virginia has problems in the area of infant health. An examination of neonatal and infant mortality rates reveals that for certain areas within Virginia problems with infant health are even more severe than for the state in general. Inadequate prenatal care for teenage and nonwhite mothers contributes substantially to this problem. Access to health care and health care information is blocked by many different barriers. These barriers are economic, attitudinal, and for many rural low-income children and families, physical. Preventable and potentially disabling conditions should be treated through primary preventive services, but to do so requires both access to services and prompt early treatment. At this time of diminished federal resources for indigent health care, providers and advocates must turn to strategies which (1) maximize the quantity and quality of client access to existing health care resources and (2) stress the development of new resources. (RH)

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Child Health Care: An Investment In the Future
Developed by the Virginia Division for Children

1981

Across the country and in Virginia, quality health care is not distributed equally among all children and their families. Children from low-income families tend to be less healthy than other children. Many women, and especially pregnant teenage women do not obtain adequate prenatal care. By examining prenatal care opportunities and health resources for low-income families, this paper will look at both the extent to which available health care in Virginia emphasizes a preventive approach and the extent to which Virginia's medically needy children have access to needed medical care.

Prenatal Care - A Must In Preventive Medicine

Mothers who have had no prenatal care are three times more likely to give birth to infants with low birth weights. Low birth weight is associated with 2/3 of all infant deaths and substantially increases the likelihood of birth defects.

In Virginia in 1979, 62,258 women (81% of all births) began prenatal care in the first trimester.¹ 2,075 women (2.7% of all births) did not obtain prenatal care until the third trimester and 527 women did not obtain prenatal care at all.²

Births to teenage mothers frequently result in more complications for both the mother and child, due to the teenage mother's tendency toward incomplete physical development, poor diet, and the emotional stress associated with pregnancy. In 1979, only 60% of teenage mothers, in Virginia

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sought prenatal care in the first trimester of pregnancy.³

To what extent is infant health a significant problem in Virginia? Though infant and neonatal mortality rates have declined dramatically,⁴ infants in Virginia continue to experience significantly higher rates of mortality than do infants in the country as a whole. In 1979, the U.S. infant mortality rate was 13.0 (deaths per 1000 live births) as compared to 14.8 in Virginia.⁵ For the same year, the neonatal mortality rate⁶ for the U.S. was 8.7, as compared to 10.9 in Virginia. In Virginia, infant mortality among blacks is nearly twice the rate among whites.⁷ Within Virginia, some areas show infant and neonatal mortality rates 1 ½-2 times the States average.⁸

National statistics characterize inadequate prenatal care as related to births of immature (low birth weight) infants. In Virginia in 1979, 5,814 babies (7.6% of all births) were immature.⁹ As is the pattern with other infant health measures, a disproportionate number of low birth weight babies are born to black mothers - 11.7% of babies born to black mothers are immature, as compared to 6.1% of babies born to white mothers.¹⁰ Consistent with the categorization of births to teenage mothers as troubled, teenage mothers are more likely than other mothers to give birth to low-birth-weight infants.

In sum, Virginia has some significant problems in the area of infant health, as compared to the country as a whole. An examination of neonatal and infant mortality rates reveals that, for certain areas within Virginia, problems with infant health are even more severe. Inadequate prenatal care contributes to this problem; and substantially fewer teenage mothers and nonwhite mothers obtain adequate prenatal care.

The Problem: Access to Health Care
and Health Care Information

The State Health Department estimates that 490,000 children in the Commonwealth of Virginia are "medically indigent" - that is, from families who lack sufficient income to meet their children's medical needs.¹¹ At any one time, approximately 130,000 of these children receive assistance from the Medicaid program.¹² The remaining 360,000 children are left to simply go without medical care or to seek care through a maze of state and federal programs for which many of them will not be eligible (or to otherwise attempt to secure care). Barriers to adequate health care for medically indigent children are, in many cases the same as those faced by low-income women and teenagers in obtaining adequate prenatal care. These barriers are economic, attitudinal, and for many rural low-income children and families, physical.

Low-income families who cannot pay for medical care face economic barriers to health services. Mothers and children in intact (two parent) families, even where one parent is suffering short-or long-term unemployment, are ineligible in Virginia for Medicaid coverage. A low-income woman who is pregnant for the first time can become eligible for Medicaid coverage upon the birth of the child, but she cannot get assistance from Medicaid for prenatal care expenses. Some physicians and hospitals in Virginia require cash "up-front" prior to treatment. A low-income family which could possibly make smaller payments over time may have to forego medical service for lack of this deposit.

Attitudes held by low-income clients as well as by providers are another barrier to medical care. Lacking the resources of more affluent

families and living in a constant state of insecurity, many low-income families tend, by definition and necessity, to be "present"-oriented with their attention and limited resources focused on solving immediate problems and meeting immediate needs. This "crisis" dilemma frequently means that preventive health care (for example, prenatal care) is a luxury, which is not sought if money is scarce or non-existent.

Health care professionals do not always understand the language or culture of low-income clients. While all programs cannot be staffed with individuals who share the clients' ethnic or cultural backgrounds, an applied understanding of and sensitivity to clients' lifestyles will increase the likelihood that parents will understand their children's problems and follow the suggested treatment instructions.

There are, as well, physical barriers which interfere with the ability of low-income families to obtain needed medical care. Many low-income people depend upon local health departments for medical care. Frequently, health departments hold clinics only during working hours; often transportation is not available at those times and/or parents must miss work in order to get medical attention for themselves or their children. While there has been increasing publicity about health services available to children and pregnant women, some parents are still not aware of the various sources of medical assistance, and not all service providers have been aggressive in marketing their programs.

Information barriers exist when children, parents, and providers remain undereducated about simple preventive steps to good health care.

Attempts to overcome these barriers and disseminate health care information must be ongoing; as one affected group becomes educated about how they can maintain good health (and prevent, for example, fetal alcohol syndrome, nutritional problems and accidental poisonings) they are replaced by others who will need to learn the same information. Such health care information should include information focussing on the increasing problems relating to substance abuse (and the health effects of using "look-alikes" or counterfeit drugs), family planning needs, and use of car restraints for infants, etc. As new information becomes available from research/experience, more successful means of timely communication must be used.

Physical barriers to obtaining medical attention in rural areas are especially formidable. In rural sections of Virginia, physicians are in short supply - lack of physicians in private practice also means a lack of physicians available to help staff local health departments. Some rural health departments do not have prenatal care or "sick child" clinics. These problems, combined with long distances to clinics and hospitals (and related transportation problems) make the possibilities for rural access to health care appear very limited indeed.

Reductions in Federal funds for services to handicapped children through Bureau of Crippled Children's Services will significantly impair handicapped children's access to rehabilitative services. In the Division for Children's Study of the State Plan for Identification and Diagnosis of Handicapped children, some sources described that many children were not reached by BCC Services

because the income levels for free services were very low and the sliding scale for services was fairly steep. Federal funds reductions of nearly \$1.5 million dollars are forcing even greater restrictions, including limitations on hospitalization coverage and restriction of services to those conditions most readily remedied.

Improving Access and Achieving A Prevention Focus: Benefits

In these times of inflation, an ounce of prevention is now worth five pounds of cure. The list of largely preventable and potentially disabling conditions is long and includes:

Typhoid	Tooth Decay
Tetanus	Poisoning
Diphtheria	Burns
Urinary tract infections	Measles
Pregnancy	Encephalitis
Mental Retardation	Low birth weight
Down's Syndrome	Malnutrition
Whooping Cough	Impetigo
Rickets	Parasitic Disease
Amblyopia	Tuberculosis
	Fetal Alcohol Syndrome

Prevention of these and other disabling conditions entails both access to primary prevention services (especially to high-risk populations) and prompt early treatment.

Primary preventive services (which include pre- and postnatal care, child health screenings and treatment, and health education and counseling) are low-cost as compared to the expenses of acute or rehabilitative care. For example, the Virginia Department of Health has estimated that routine prenatal care (excluding hospitalization and physicians' charges for delivery) costs approximately \$100, and tends to prevent incidence of low birth weight

in babies.¹³ Low birth weight babies remain in the hospital an average of 17 days after the delivery.¹⁴ This considerable expense for hospitalization might have been avoided had the mother sought and obtained adequate prenatal care. If a low-income mother is pregnant with her first child and otherwise eligible for Medicaid, Medicaid in Virginia will pay for post delivery hospitalization but not the prenatal care which might make those costs lower.

Not all cases of low birth weight in babies or complications of pregnancy can be prevented. However, even provision of relatively expensive neonatal intensive care has been found to be cost-effective as compared to the tremendous expense of institutionalization of infants who would be permanently handicapped if they did not receive intensive care.¹⁵ The average annual cost per patient at a Mental Retardation Center in Virginia is \$17,554;¹⁶ a total of \$702,160 over a lifetime of 40 years. Even where a handicapped child remains in the home, the cost to parents and to society are high - and can include expenses for special education, hospitalization and special medical care, special diet or equipment needs, and child care requirements which may make it impossible for a parent to work outside the home.

The evidence for the cost-effectiveness of a wide range of preventive medical and dental care services is compelling for both economic and humane reasons. For example:

- In 1977, the General Accounting Office reported to Congress that the cost of genetic screening at birth plus early treatment for seven common disorders was less than one-eighth the cost of caring for an impaired child over a lifetime. This was true even without considering the effects of inflation.¹⁷

- A study in Texas looked at four types of prevention programs - vision screening, hearing screening, preventive dental care, and identification of congenital handicaps. They found that, for each State dollar spent, more than \$8 in long term care costs and income loss was saved.¹⁸

Finally, one fundamental and cost-effective method of achieving a preventional focus is dissemination of health care information which describes preventive steps individuals can take to maintain good health (for example, information about fetal alcohol syndrome, family planning, nutrition, poisoning dangers associated with prescription drugs, etc.). While primary care is more cost-effective than remediative care, health education and information provides a low-cost approach by which preventive health care can be initiated even before medical care providers become involved.

Improving Access and Achieving a Prevention Focus: Strategies

At this time of diminished federal resources for indigent health care, providers and advocates must turn to strategies which (a) maximize the quantity and quality of client access to existing health care resources and (b) stress the development of new resources. Possible strategies to be explored include:

1. Increased volunteerism by health and medical professionals.

2. Greater flexibility of operating hours at public health departments; operating some clinics with evening and/or weekend hours,
3. Community-level coordination of local private and public resources (for example, negotiated special arrangements for prenatal care and delivery expenses),
4. Implementation of a statewide public information campaign on the importance of prenatal care and early identification of handicapping conditions,
5. Greater use of nurse-practitioners particularly in providing routine, preventive care,
6. Use of health vans - mobile health units - especially in rural areas,
7. More efficient use of school nurses in teaching the importance of preventive health care,
8. Extension of private health insurance to cover regular, preventive checkups, and
9. Expanded use of health fairs.
10. Preparation and dissemination of information about some lesser known medical care assistance resources (for example, Hill-Burton, State Indigent Care funds, and State-Local Hospitalization),
11. Coordination and dissemination of timely health care information

In addition, providers and advocates may develop local child health resource inventories which identify local needs and potential State and local resources to meet them.

Footnotes

¹Virginia Department of Health, Center for Health Statistics, 1979.

²Ibid.

³See Table 1 in Appendix.

⁴See Table 2 in Appendix.

⁵Virginia Department of Health, Center for Health Statistics, 1979.

⁶Deaths within 28 days after birth.

⁷Virginia Department of Health, Center for Health Statistics, 1979.

⁸See Table 3 in Appendix.

⁹Virginia Department of Health, Center for Health Statistics, 1979.

¹⁰Ibid.

¹¹Virginia Department of Health, State Health Plan, 1980-84.

¹²Ibid.

¹³Correspondence from Ann Cook, Virginia Medical Assistance Program to Steve Biehn, September, 1980.

¹⁴Ibid.

¹⁵Virginia Department of Health, State Health Plan, 1980-84.

¹⁶As of September 30, 1979.

¹⁷Government Accounting Office, "Preventing Mental Retardation - More Can Be Done," U.S. Government Printing Office, HRO-77-37, October 3, 1977.

¹⁸C. Beeley and J.S. Liston, "Early Childhood Development Programs in Texas: An Analysis of Benefits and Costs," Texas Department of Community Affairs, May, 1975.

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- (1) State Health Plan, 1980-84. Virginia Department of Health, 1981.
- (2) Data to be published in Annual Report, 1979, Virginia Department of Health, Center for Health Statistics.
- (3) "Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome," Government Accounting Office, January, 1980.
- (4) "Report on the Needs of Medically Indigent Children in Virginia to the Governor and the General Assembly of Virginia," House Document No. 27, 1981.
- (5) "Outpatient Care in Virginia," Joint Legislative Audit and Review Commission," March 13, 1979.
- (6) "Inpatient Care in Virginia," Joint Legislative Audit and Review Commission, January 2, 1979.
- (7) National Center for Health Statistics, Monthly Vital Statistics Report, Summary 1973.
- (8) National Foundation, Annual Report, 1974. Cited in America's Children, 1976, A Bicentennial Assessment.
- (9) Priscilla Guild, "Infant Mortality and Teenage Pregnancy. - A Profile of Children in the South." Southern Growth Policies Board, Task Force on Southern Children, April, 1980.

APPENDIX

Table 1
Percentage of Births in Virginia by
Trimester Prenatal Care Began

<u>1972</u>			
<u>Trimester Care Began</u>	<u>Mother 15 Years</u>	<u>Mother 15-19 Years</u>	<u>All Mothers</u>
First	35.9	50.4	67.2
Second	40.7	36.9	25.3
Third	16.1	9.6	5.4
None	(5.6) ¹	2.0	1.1
Unknown	(1.4)	.8	.7
<u>1979</u>			
First	44.7	63.3	81.0
Second	40.2	28.4	14.8
Third	10.6	5.8	2.7
None	(4.1)	1.7	.6
Unknown	(.4)	.6	.9

¹ Parentheses indicate percentage is based on fewer than 20 cases.

Source: Advance data, to be published in Annual Report, 1979, Virginia Department of Health, Center for Health Statistics.

Table 2
 Infant and Neonatal Mortality Rates¹
 for Virginia, 1972 and 1979

Infant Mortality

<u>Year</u>	<u>Total</u>		<u>White</u>		<u>Nonwhite</u>	
	<u>Number</u>	<u>Rate</u>	<u>Number</u>	<u>Rate</u>	<u>Number</u>	<u>Rate</u>
1972	1,524	20.3	986	17.2	538	30.5
1979	1,135	14.8	712	12.5	423	21.0

Neonatal Mortality

1972	1,161	15.5	768	-	393	-
1979	835	10.9	530	9.3	305	15.1

¹ Rates per 1,000 live births

Source: Advance data, to be published in Annual Report, 1979, Virginia Department of Health, Center for Health Statistics.

Table 3

Infant and Neonatal Mortality
Rates¹ for Virginia and Certain
Planning Districts, 1979

Infant Mortality			
	<u>Total</u>	<u>White</u>	<u>Nonwhite</u>
<u>Virginia</u>	14.8	12.5	21.0
<u>Highest Rates</u>			
PD 19	21.9	18.5	25.3
PD 1	21.6	21.3	(35.7) ²
<u>Lowest Rates</u>			
PD 8	9.7	8.4	16.0
PD 7	11.7	(11.8)	(10.9)
Neonatal Mortality			
	<u>Total</u>	<u>White</u>	<u>Nonwhite</u>
<u>Virginia</u>	10.9	9.3	15.1
<u>Highest Rates</u>			
PD 1	17.6	17.3	(35.7)
PD 19	16.4	(11.8)	21.0
<u>Lowest Rates</u>			
PD 8	6.6	6.2	8.8
PD 6	8.6	8.3	(12.5)

¹ Rates per 1000 live births

² Parentheses indicate rates based on fewer than 20 cases.

Source: Advance data, to be published in Annual Report, 1979, Virginia Department of Health, Center for Health Statistics.

Table 4
Percentages of Immature Births
in Virginia, by Age and Race of Mother,
1972 and 1979

	<u>1972</u>		
	<u>Mothers 15 Years</u>	<u>Mothers 15-19 Years</u>	<u>All Mothers</u>
Total	18.9%	10.5%	7.9%
White	17.5%	8.0%	6.5%
Nonwhite	19.4%	14.4%	12.8%

	<u>1979</u>		
	<u>Mothers 15 Years</u>	<u>Mothers 15-19 Years</u>	<u>All Mothers</u>
Total	16.4%	10.8%	7.6%
White	15.5%	8.6%	6.1%
Nonwhite	16.9%	13.9%	11.7%

Source: Advance data, to be published in Annual Report, 1979, Virginia Department of Health, Center for Health Statistics.